

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address: EAST TEXAS MEDICAL CENTER 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-06-3791-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Box #: EAST TX EDUCATIONAL INS ASSN Rep Box # 11	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Though there is no specific fee guideline to follow for outpatient surgery/services and the reimbursement is to be at a 'fair and reasonable' rate, we don't believe the payment received was quite 'fair'. Your payment was 24% of total charges. The operating cost-to-charge ratio for East Texas Medical center during this date of service was 21%. We are asking you to take this into consideration and re-review this claim as your payment did not meet the operating cost for this claim."

Requestor's Rationale for Increased Reimbursement on the *Table of Disputed Services*: "No ASC allowable or Medicare all req reimbursement @ 75% of bill." [sic]

Principal Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$1203.16
3. Hospital Bill
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Unbundling, multiple procedure rule, Pursuant to Texas Labor Code 413.011, reviewed to a standard of reasonableness based on current industry benchmarks and comparable services in the provider's geographical area."

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
02/28/2005	226, 426, 150, 97, F, G, M, S01, S04, S14	Outpatient Surgery	\$1203.16	\$0.00
Total /Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - 226-Included in global charge.

- 426-Reimbursed to fair and reasonable. These services were reviewed by an outside vendor and reimbursed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area. A copy of this review has been enclosed.
 - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
 - 97-Payment is included in the allowance for another service/procedure.
 - F-Fee guideline MAR reduction.
 - G-Unbundling.
 - M-No MAR.
 - S01-Pursuant to Texas Labor Code 413.011 and other applicable statutes this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area.
 - S04-Separate reimbursement for this line item is denied. The clinical information and detail submitted on the procedures rendered, indicates that separate reimbursement for this line item would be inappropriate or has been included in the value of the procedure performed.
 - S14-The line item was reduced according to the multiple surgery rule.
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011.”
 3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
 4. Division rule at 28 TAC §133.307(e)(2)(A), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires that the request shall include “a copy of all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.304.” This request for medical fee dispute resolution was received by the Division on January 30, 2006. Review of the documentation submitted by the requestor finds that the requestor has not submitted a copy of the original bill. Therefore, the requestor has failed to complete the required sections of the request in the form, format, and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(e)(2)(A).
 5. Division rule at 28 TAC §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including “a copy of any pertinent medical records”... Review of the submitted evidence finds that the requestor has not sent a copy of any pertinent medical records. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(B).
 6. Division rule at 28 TAC §133.307(g)(3)(C), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including “a statement of the disputed issue(s) that shall include: (i) a description of the healthcare for which payment is in dispute, (ii) the requestor’s reasoning for why the disputed fees should be paid or refunded, (iii) how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue. Review of the submitted documentation finds that the requestor did not discuss or explain how the Texas Labor Code and Division rules impact the disputed fee issues, or how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C).
 7. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines)”. The requestor asserts in the position statement that “Though there is no specific fee guideline to follow for outpatient surgery/services and the reimbursement is to be at a ‘fair and reasonable’ rate, we don’t believe the payment received was quite ‘fair’. Your payment was 24% of total charges. The operating cost-to-charge ratio for East Texas Medical center during this date of service was 21%. We are asking you to take this into consideration and re-review this claim as your payment did not meet the operating cost for this claim.” Furthermore, the requestor asks for increased reimbursement on the *Table of Disputed Services*: “No ASC allowable or Medicare all req reimbursement @ 75% of bill.” [sic]

The requestor did not discuss or explain how it determined that the cost-to-charge ratio would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1.

Furthermore, a reimbursement methodology based on hospital costs does not, in itself, produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models” ... “are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital’s charges cannot be verified as a valid indicator of its costs.” ... “Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs.”

Additionally, the Division found that a reimbursement methodology based upon payment of the hospital’s billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the same fee guideline adoption preamble as above which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living.”

Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment in the amount sought by the requestor would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(A), §133.307(g)(3)(B), §133.307(g)(3)(C) and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §133.304, §134.401, §133.301
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

2/11/2010

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.